# Home Health and Hospice Weekly: Recap of LeadingAge Updates

November 4, 2022

**Coronavirus Calls Next Week. All calls are at 3:30 PM ET. What do the midterm elections mean for aging services? What's bringing voters out?** Regardless of your political party, the midterm election, set for Tuesday, November 8, will do a lot to clarify how policy decisions will be made on Capitol Hill. The entire House of Representatives and a third of the Senate will be decided. On **Monday, November 7**, join us as we chat with **Jonathan Voss**, Partner at Lake Research Partners, a national public opinion and political strategy research firm. Jonathan will share insights from survey research on how voters are thinking about issues related to older people and aging services and discuss what the outcomes of the election might mean for the short and long term. the midterm elections. **Did resident engagement change during the pandemic? If so, how, and are the changes going to last? On Wednesday, November 9, Teresa Scott,** President and CEO of Penney Retirement Community in Green Cove Springs, Florida will be with us to talk about a unique model of resident engagement and how it helped Penney get through the pandemic. If you haven't registered for LeadingAge Update Calls, you can do so here. You can also find previous call recordings here. Note that to access recordings of the calls you need a LeadingAge password. Any staff member of any LeadingAge member organization can set up a password to access previous calls and other "members only" content.

**CMS Updates HCPCS Payment Codes for Chaplain Services**. As of October 1, 2022, CMS updated three payment codes regarding chaplain services to allow for greater use. Previously, chaplains had what are called healthcare common procedure coding system or HCPCS Level II codes but they could only be used at the Department of Veterans Affairs. Read more about this change and what it means for providers in this article.

**CMS Releases Hospice VBID Report.** CMS released a new report and Findings at a Glance document reviewing the outcomes of the Value-Based Insurance Design Hospice Component for 2021 as known as the hospice Medicare Advantage carve-in demonstration. In 2021, nine MA plans implemented the program in 52 different plan offerings. Key findings include:

- The Hospice Benefit Component represents a notable departure from how the hospice benefit has been delivered to MA enrollees.
- Both MA plans and hospices indicated substantial implementation challenges, which diminished with time.
- Uptake of palliative care, transitional concurrent care, and hospice supplemental benefits were lower than expected.
- Participation in the Hospice Benefit Component was not associated with changes in plan-level enrollment, combined MA with Part D bids and premiums, or projected costs of mandatory supplemental benefits.

**CMS Home Health, Hospice, and DME Open Door Forum Announced.** On Wednesday, November 9, 2:00 – 3:00 PM ET, CMS will host an Open Door Forum for Home Health, Hospice and Durable Medical Equipment (DME) providers. On the agenda is the CY2023 Home Health Prospective Payment Final Rule,

Home Health Quality Reporting Program, Hospice Quality Reporting Program, and Home Health Value Based Purchasing updates. To participate by phone: Dial: 1-888-455-1397 & Reference Conference Passcode: 5109694

**Article on final Home health rule available.** The final CY2023 Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Requirements was released on the Federal Register public inspection site on October 31st. The permanent cut was finalized at 3.952% vs. the originally proposed 7.69% and finalize the market basket update at 4% instead of the originally proposed 2.9%. Those changes mean aggregate payments for home health will increase by .7% compared to CY2022. Read more about what was in the final rule here.

**Final Home Health PPS Rule Published; Cut Reduced by Half; LeadingAge continues to advocate for change in methodology.** On Monday October 31 at 4:15 PM ET CMS released the final Home Health prospective payment rule. CMS back off on their initial proposed cut; CMS estimates that Medicare payments to HHAs in CY 2023 will increase in the aggregate by 0.7%, or $125 million, compared to CY 2022, based on the finalized policies. This increase reflects the effects of the 4.0% home health payment update percentage ($725 million increase), an estimated 3.5% decrease that reflects the effects of the prospective permanent behavioral assumption adjustment of -3.925% ($635 million decrease) that is being phased-in, and an estimated 0.2% increase that reflects the effects of an update to the fixed-dollar loss ratio (FDL) used in determining outlier payments ($35 million increase). CMS notes that the overall impact of the -3.925% permanent behavioral assumption adjustment is -3.5%, as the permanent adjustment is only made to the 30-day payment rate and not the Low Utilization Payment Adjustment (LUPAs) per visit payment rates. While we appreciate that CMS did not go through with their full proposal, we remain concerned with the underlying methodology and its impact on our members as well as the impact of future cuts (CMS delayed phasing in their full proposal for CY2023 only). The rule fact sheet can be found here and the rule itself can be found here. LeadingAge staff experts are developing essential advocacy, guidance, and tools, and curating the most relevant resources for aging services providers, including No staff, no care: LeadingAge Reacts to CMS Home Health Payment Rate Update.

**LeadingAge Statement on Home Health Final Rule.** LeadingAge staff experts are developing essential advocacy, guidance, and tools, and curating the most relevant resources for aging services providers, including No staff, no care: LeadingAge Reacts to CMS Home Health Payment Rate Update.

**MedPAC Discusses Quality through a Disparity Lens and Unified PAC PPS**: On November 3, LeadingAge staff attended the first of MedPAC's two-day November meetings. Of interest to LeadingAge members, were two key topics: 1) the future of quality measurement that examines disparities in outcomes; and 2) a comparison of MedPAC's prototype for a Unified post-acute care(PAC) prospective payment system(PPS)with the CMS/ASPE model. At this meeting there was much discussion and few conclusions. Both issues received positive responses from commissioners who seek for work to continue on these issues. During the quality discussion, MedPAC staff shared an analysis of how many beneficiaries returned to community from SNF and HH broken down by income status and race/ethnicity. The data showed lower rates of successful discharge to community for low-income individuals who utilized SNF care and there was a 10% difference in the return to home rates when comparing outcomes by race/ethnicity for the low-income population. In contrast. home health showed little difference between low income and non-low income in return to home and only small variations in the ability to return to home by race. The commissioners asked staff for a number of additional

clarifications to determine why the outcomes were so different between the two settings including whether there was a selection bias. On the topic of the unified PAC PPS, staff walked through how the MedPAC model compared to the CMS/ASPE model. The CMS/ASPE model has some additional adjusters for SNF, LTCH and IRF; and would also provide an adjustment for rural providers. MedPAC staff indicated they did not believe the rural adjustment was needed as the modeling shows rural provider PAC rates would increase 3% under the model. All commissioners agreed more discussion was necessary on this topic but that much has changed in PAC payment since this work began 10 years ago. No recommendations were made at this meeting

**Feedback Sought on Proposed List of Screening Tools for Collecting Social Risk Factor Data.** CMS has issued a 60-day notice of a proposed list of screening tools that Special Needs Plans (SNPs) would be permitted to use to comply with the new requirement to include one or more questions on housing stability, food security and access to transportation in their Health Risk Assessments as of January 1, 2024. The list appears to include some tools used by post-acute care providers such as PROMIS and OASIS but there may be others that provider-led SNPs would prefer to use and would like CMS to consider as part of its list. This information can be shared as a comment to CMS. The related guidance and list of proposed screening tools can be found here. Comments must be submitted by December 27, 2022 and can be submitted in any format electronically by identifying the guidance document CMS-10825 at: http://www.regulations.gov/

**CMS Finalizes Rule Revising Several Medicare Enrollment and Eligibility Situations**: Final rule CMS-4199-F changes to the effective date of an individual's Medicare coverage when they first enroll to the month after enrollment to eliminate coverage gaps. It also adds 5 new Special Enrollment Periods allowing individuals an opportunity to enroll under certain exceptional situations such as being impacted by an government-declared emergency or disaster, or if a plan or employer misrepresented information regarding their enrollment. It will extend coverage of immunosuppressive drugs for those with ESRD beyond their post-transplant Medicare coverage period. The rule also requires states to incorporate their buy-in agreements detailing their payment of Medicare A and B premiums for low-income individuals. Currently, these terms are in a separate document. It also limits states liability for retroactive Part B premium payments when SSA determines a Medicaid beneficiary is retroactively eligible for Medicare Part A.

**Coalition letter urges Congress to approve higher domestic and international spending levels.** On November 1, LeadingAge joined a coalition of more than 400 national, state, and local organizations urging Congress to enact an omnibus government funding bill that includes domestic and international program amounts that are no less than those proposed by the House of Representatives for Fiscal Year 2023. Domestic and international programs -- also known as non-defense discretionary spending, or NDD – proposed by the House of Representatives are higher than amounts proposed by the Senate. As House and Senate appropriators work to set 2023 spending levels, LeadingAge is working with its coalition partners to advocate for the strongest possible program funding that supports older adults and their families. You can read the coalition letter here.

**CMS Finalizes New Rural Emergency Hospital rule:** Typically, we do not share updates on hospital rules but on Nov. 1, CMS released its calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule, which includes a new Medicare provider type that will be allowed to have Skilled Nursing Facility beds. The rule outlines the enrollment procedures, payment rates and conditions of participation for this new Medicare provider

type, Rural Emergency Hospital (REH). Under this final rule, Critical Access Hospitals (CAHs) and small rural hospitals are permitted to convert to be an REH, which may be a more sustainable option for rural hospitals facing closure and supports access to care in rural and underserved communities. REHs are limited to not more than 50 beds and do not provide acute care inpatient services, with the exception of post-hospital extended care services furnished in a distinct part unit licensed as a skilled-nursing facility. If rural hospitals and CAHs convert to this new provider type it may impact care delivery patterns in some rural communities as inpatient acute care services will no longer be available. In addition, outpatient services provided by REHs will be paid at 105% of the OPPS fee schedule but it should be noted that SNF services are not considered REH services and as such, will be paid based upon SNF PPS and not receive the additional 5% rate increase. REHs will be subject to their own Quality Reporting Program. In this rule, Medicare will also pay hospital outpatient departments to provide remote behavioral health services to people at home, which is designed to improve access to care in rural communities and promote health equity. For a fact sheet on the Rural Emergency Hospitals, click here and the complete rule can be found here.

**FROM CDC/HHS:**

1. **Racial and Ethnic Disparities in Outpatient Treatment of COVID-19:** CDC published an *MMWR* on racial and ethnic disparities in outpatient treatment of COVID-19 in the United States from January to July, 2022. Outpatient medications are effective at preventing severe COVID-19 and are important to pandemic mitigation. Paxlovid is the most commonly prescribed medication and the preferred outpatient therapeutic for eligible patients. Racial and ethnic disparities persisted in outpatient COVID-19 treatment through July 2022. During April–July 2022, the percentage of COVID-19 patients aged ≥20 years treated with Paxlovid was 36% and 30% lower among Black and Hispanic patients than among White and non-Hispanic patients, respectively. These disparities existed among all age groups and patients with immunocompromise. Expansion of programs to increase awareness of and access to available outpatient COVID-19 treatments can help protect persons at high risk for severe illness and facilitate equitable health outcomes.
2. **Notes From the Field: Dispensing of Oral Antiviral Drugs for Treatment of COVID-19 by Zip Code–Level Social Vulnerability:** CDC published an *MMWR* on dispensing of oral antiviral drugs for treatment of COVID-19 by zip code–level social vulnerability in the United States from December 23, 2021 to August 28, 2022. Equitable access to COVID-19 therapeutics is a critical aspect of the distribution program led by the U.S. Department of Health and Human Services (HHS). Two oral antiviral products, nirmatrelvir/ritonavir (Paxlovid) and molnupiravir (Lagevrio), received emergency use authorization (EUA) from the Food and Drug Administration (FDA) in December 2021, to reduce the risk for COVID-19–associated hospitalization and death for those patients with mild to moderate COVID-19 who are at higher risk for severe illness. HHS has been distributing these medications at no cost to recipients since their authorization. Data collected from provider sites during December 23, 2021 to May 21, 2022, indicated substantial disparities in the population-adjusted dispensing rates in high social vulnerability (high-vulnerability) zip codes compared with those in medium- and low-vulnerability zip codes. Specifically, dispensing rates for the 4-week period during April 24 to May 21, 2022, were 122 per 100,000 residents (19% of overall population-adjusted dispensing rates) in high-vulnerability zip codes compared with 247 (42%) in medium-vulnerability and 274 (39%) in low-vulnerability zip codes. This report provides an updated analysis of dispensing rates by zip code–level social vulnerability and highlights important intervention strategies.
3. **COVID-19's Lasting Impact on the Body:** NIH released a news story on COVID-19's lasting impact on the body. Researchers at the NIH Clinical Center, the National Institute of Dental and Craniofacial Research (NIDCR), and the National Institute of Allergy and Infectious Diseases (NIAID) performed autopsies on the bodies of patients with COVID-19. The researchers found that even in patients who

had mild or asymptomatic cases of COVID-19, evidence of SARS-CoV-2 infection was present throughout the entire body and stayed there until the patients' deaths, which in some cases occurred more than seven months after the start of symptoms. The researchers examined tissue from many different sites in the body from 44 patients who had died of COVID-19 or who had tested positive for the disease before they died. The autopsies were performed at the NIH Clinical Center between April 2020 and March 2021. Analysis of the patients' samples revealed SARS-CoV-2 in almost every organ and organ system of their bodies, including their skin, eyes, stomachs, muscle, fat, glands, and six different parts of their brains. SARS-CoV-2 was present even in asymptomatic patients, patients who had had mild cases of COVID-19, and patients who had first been diagnosed with the disease months before their death. This suggests that even mild cases of COVID-19 spread quickly and the virus can remain in our tissue for a long time.